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PHILOSOPHICAL EXPLORATION

Defining and Operationalizing Chaplain Presence: A Review

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Abstract

Presence is a vaguely defined word often used by chaplains to describe their work with patients, families, and staff. The current literature defines presence as a process of creating a trusting atmosphere for nonjudgmental and compassionate sharing in another's story. Presence has no apparent agenda, much flexibility, and requires emotional vulnerability in the chaplain interactions. This presents four problems: distinguishing chaplain presence from presence by other providers; dependence on chaplain vulnerability in the encounter; difficulty of assessing impact on patient/family care; and clearly communicating the importance of presence to the interprofessional team. An operational definition is provided including parameters for care and intended outcomes.

Keywords Presence · Chaplain · Spiritual · Healthcare

Introduction

Chaplains often use the word *presence* as a key descriptor for what they uniquely bring into the patient and family encounter. In defining presence for other healthcare providers, chaplains often use concepts such as active listening, advocacy, communication, interactions free of personal and professional agendas, and spending time with patients and families. These general definitions are vague and describe an aspect of care also provided by many healthcare professionals across all disciplines. Massey et al. (2015) contend that chaplains generally do not have a consistent way of describing what they do. It also can be difficult for chaplains to identify and articulate the impact of chaplain presence on healthcare outcomes. In a qualitative study interviewing pediatric physicians and chaplains regarding chaplain contributions, "…physicians see chaplains as part of interdisciplinary medical teams where they perform rituals and support patients and families, especially around death.

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Chaplains agree but frame their contributions in terms of the perspectives related to the wholeness, presence, and healing they bring. Chaplains have a broader sense of what they contribute to patient care than do physicians (Cadge et al. 2011, p. 300)." Lyndes et al. (2012) describe this as chaplains' contributions to outcomes (physician perspective) versus the process of chaplain work (chaplain perspective). Fitchett and Grossoehme note that, "The current healthcare climate, in which chaplains are a limited resource, means they must decide how to ration their time (Roberts 2012, p. 388)." If chaplains can be specific and concrete in articulating what they do and can relate this work to the impact on care and outcomes, other healthcare vocations may develop a better understanding of what chaplains do (Lyndes et al. 2012). Yet, according to Mowat, "…the research literature as it currently stands does not directly or substantially address the issue of efficacy in healthcare chaplaincy (Mowat 2008, p. 31)." If spiritual care positively affects healthcare outcomes, if chaplains are the primary providers of this care in the healthcare context, and if presence truly is a central component in the chaplains' provision of spiritual care then chaplains need to be able to adequately define presence and its role in the provision of spiritual care.

The purpose of this article is twofold. First, it assesses the current understanding of chaplain presence through a review of the literature. Second, it offers a recommended definition of chaplain presence that may be used to add to the further development of evidence-based spiritual care.

Literature Review

The concept of chaplain presence is part of chaplain training and continues to be expressed in their ongoing professional development and identity. The literature review is divided into five groups: identification and understanding of presence by a professional chaplaincy training organization and a professional chaplain cognate group; common definitions of the word itself; the role and function of the chaplain articulated by professionals both within and outside chaplaincy; presence in other healthcare disciplines, specifically physicians and nurses; and consistent articulation of chaplain presence in the interprofessional context.

Professional Organizations

The Association for Clinical Pastoral Education (ACPE) is one of the principle organizations that train professional chaplains. Standard 312 Outcomes of Clinical Pastoral Education (CPE) Level II Pastoral Competence 312.6 says the student will, "demonstrate competent use of self in ministry and administrative function which includes: emotional availability, cultural humility, appropriate self-disclosure, positive use of power and authority, a non-anxious and nonjudgmental presence, and clear and responsible boundaries (Association for Clinical Pastoral Education, Inc. 2016)." This standard encourages a presence guided by self-disclosure and emotional availability while maintaining a clear sense of boundaries.

The Association of Professional Chaplains (APC) is the largest chaplain cognate group in the USA. APC identifies eight overarching principles in its guidelines for the chaplain's role in healthcare ethics. In its interpretation of Principle V, chaplains provide pastoral and spiritual care to those involved in the ethical reflection process, APC identifies yet does not define presence, stating,

> The ministry of Chaplains includes a wide repertoire of services including pastoral presence, pastoral conversation, pastoral/spiritual care, and pastoral counseling. Experiencing such services, patients, families, health care staff, and employees feel affirmed, understood, and supported in their particular predicament and in their right to have a particular ethical perspective. Those involved in the process can be enabled to explore the relationships of the physical issues of health and illness, psychological dimensions of the situation, i.e., anxiety, fear, trust, etc., and the spiritual issues, i.e., meaning, hope, ultimate concern, and God's presence. Issues vary greatly from person to person depending upon the situation and belief system of the individual. Pastoral/spiritual care offers support for all involved and creates an atmosphere of sensitivity and trust in the context of health care ethics decision-making (Association of Professional Chaplains 2015).

Common Definitions

Broadly, presence is "the fact or condition of being present; the state of being before, in front of, or in the same place with a person or thing; being there; attendance, company, society, association (*The compact edition of the oxford english dictionary* 1971, p. 2284)." While this may be applicable to most, if not all, relationships with the patient/family system in the healthcare context, to chaplains, presence seems to carry a special significance. Presence is a key descriptor and concept in both chaplaincy education and chaplain professional identity, yet appears to lack a concrete comprehensive definition.

The Dictionary of Pastoral Care and Counseling says the ministry of presence, "has come to mean a form of servanthood (*diakonia*¸ ministry) characterized by suffering, alongside of and with the hurt and oppressed—a *being*, rather than a doing or telling…The ministry of presence in the pastoral office means vulnerability to and participation in the life-world of those served (*Dictionary of pastoral care and counseling* 1990, pp. 950–951)." It should be noted that this description is grounded in a specifically Christian context. Other dictionary definitions of presence include spiritual and/or religious themes implying there is a connection between spirituality and the concept of presence:

- "A supernatural influence to be felt nearby (Morris 1976, p. 979)"
- "an influence or a supernatural or divine spirit felt to be present (Guralnik 1980, p. 1124)."
- "In reference to the manner in which Christ is to be held present in the Eucharist (*The compact edition of the oxford english dictionary* 1971, p. 2284)."

- "Something present, a present being; a divine, spiritual, or incorporeal being or influence felt or conceived as present (*The compact edition of the oxford english dictionary* 1971, p. 2285)."

Role and Function of the Chaplain

In a reflection on presence based on 30 years of work as an Episcopal priest, spiritual director, and chaplain, Guenther sees presence as response to suffering and the hope for healing that may or may not include cure from disease (Guenther 2011). This healing is tied to a willingness to let go of a specific outcome, implying a certain passivity in healing. Healing presence for her is fundamentally about listening, simply absorbing as the other is telling their story. And for Guenther, telling the story is the centerpiece of healing. Further, she notes that the work of healing requires the listener to be vulnerable, to, "give ourselves in compassionate presence and then let go (Guenther 2011, p. 654)."

In a reflection article, Cooper (2018) identifies a chaplain role as that of Story Catcher, the intentional listening and hearing of another's story as both fundamental and peculiar (Cooper 2018). There is an implication that listening to someone's story is unique to the chaplain. She also asserts that sharing in the story involves a level of risk and vulnerability for both the teller and the hearer. Since the patient narrative, or story, is important to all members of the interprofessional team, the uniqueness of the chaplain role hearing the story may lie in the manner in which the story is framed in the chaplain interaction. For Cooper, identifying the potential for transcendence through storytelling in a spiritual context is a key component of chaplain interactions.

In the discussion of a case study of a chaplain providing nonreligious spiritual care, Nolan (2016) identified the chaplain response to the patient's and family's religious/spiritual instincts (Nolan 2016). For Nolan, presence is core to spiritual care describing it using Buber's nonrational, "I-Thou" communication and Frankl's, "unconscious connection that transcends objective rationality and communicates without words in the subjective and immediate (Nolan 2016, p. 14)." "In every encounter, I aim to communicate that my attention is focused fully on the person I am with and that, for those few moments, I am entirely with them (Nolan 2016, p. 14)."

In a qualitative study of chaplains working in palliative care settings, Nolan (2011) focused on the patient and chaplain responses to presence (Nolan 2011). The initial evocative response to chaplain presence may be positive or negative. After negotiating the initial response, the chaplain established an accompanying presence which was an ability to stay with the patient and do so without a therapeutic aim or professional agenda. This accompanying presence, "…allows the patient to be the being they are rather than the being the chaplain, or anyone else, may need them to be (Nolan 2011, p. 24)." This seems to imply that having a therapeutic aim in a spiritual care conversation is contraindicated for effective spiritual care. Next, the patient may derive spiritual strength through a comforting presence with the chaplain building trusting relationships and remaining authentic to the patient experience. Finally,

a hopeful presence may help the patient find a sense of hopefulness that is focused on the importance of relationships in the present. For Nolan, understanding presence is found in the activity of responding to and negotiating the relationship between the patient and the one present.

Parameshwaran (2015), a psychiatrist who completed a 1-year CPE residency, likens chaplain listening presence to mindfulness-based interventions (MBI). He describes mindfulness as a, "meditative art of being in a state of nonjudgmental, compassionate and purposeful awareness of thoughts and feelings that arise in the present moment within an individual (Parameshwaran 2015, p. 22)." For the chaplain, this awareness includes not only care of the recipient but also of the chaplain him/herself and this awareness has the potential to bring healing for both the recipient and chaplain. This implies a vulnerability in the process not only for the recipient but also for the chaplain offering this listening presence.

As part of a qualitative study of pediatric palliative care (PPC) programs, researchers interviewed chaplains and medical directors regarding the role and contributions of chaplains to the PPC teams (Lyndes et al. 2012). Chaplains focused on the process of their work while medical directors focused on contribution to outcomes. Chaplains described the perspective they bring, while the medical directors described the tasks chaplains perform. Chaplain self-descriptors focused on presence. The medical directors described chaplain contributions to three key outcomes: relieving the spiritual suffering of patients and family, improving family–team communication, and addressing the spiritual needs of the PPC team (Lyndes et al. 2012). These outcomes represent a more operationalized understanding of chaplain presence. While the article does not directly address the meaning of presence, it does identify activities and perspectives the chaplain's presence offers.

In a qualitative study by Cadge et al., chaplains described the activity of being present. They used descriptors such as, "…there's a real need to hold people in crisis,…We don't provide answers…we provide companionship…there's a kind of freedom to be with a person as opposed to having to accomplish something (Cadge et al. 2011, p. 308)." Again, this manner of interpreting the chaplain's work is broad and general. This is in contrast to the physicians interviewed who saw the chaplain contribution in the specific functions of rituals, support, and counseling.

A qualitative study of patient and family perceptions of chaplain presence by McCormick and Hildebrand identified three principle concepts: presence, relationship, and meaning (McCormick and Hildebrand 2015). Patients and families described these concepts by first listing desired traits then desired chaplain qualities and actions. For the participants, presence begins with simple availability, the willingness to unobtrusively be there. Once the chaplain is there, desired qualities are: sensitivity to the level of interaction needed; being positive and hopeful but with regard to patient suffering at a given moment; a consistently calm, gentle, and respectful demeanor; ability to listen and follow the patient's lead without being too talkative or assertive; and demonstrate compassion and empathy without judgment. "The kind of chaplain presence patients spoke of most favorably required an evolving balance of qualities dictated by the changing needs of the participants in each encounter (McCormick and Hildebrand 2015, p. 68)." It is not known from this study if these desired qualities and traits were unique to chaplains as there was no

discussion of qualities patients and families desired of other members of the interprofessional team.

Presence in Other Disciplines, Physicians, and Nurses

Using a health services framework of structure, process, and outcome Daaleman reviewed three studies of spiritual care (Daaleman 2012). It noted that nursing studies have already begun qualitative work on process in spiritual care, "describing nursing provider perspectives and reporting activities such as referring to others, facilitating religious rituals and practices, and being present to patients (Daaleman 2012, p. 1027)." One of the three reviewed studies, a qualitative study of healthcare professionals who provide spiritual care identified three domains of spiritual caregiving: presence, opening eyes, and co-creating. Presence was a dominant theme and was marked by intentionally and purposefully providing care beyond medical treatment attending to emotional, social, and spiritual needs. Key components were physical proximity, facilitating communication that was fully attentive, and sometimes transcended verbal and non-verbal communication (Daaleman 2012). This suggests that spiritual care is an interdisciplinary form of care, and the provision of that care includes presence regardless of the discipline providing it.

The writings of physician authors Abraham Verghese and Atul Gawande imply a reflective aspect in the care provided by physicians. There is an element of care that transcends the science of medicine requiring the physician to establish a listening presence that explores a patient's questions of hope and meaning (Gawande 2014; Verghese 1994).

In a qualitative study of interviews of 25 nurses at a single medical center, Bone et al. (2018) identified both chaplain presence and nursing presence to be important components of patient care. "Given the large amount of time that nurses spend at the bedside with their patients, their presence was considered to be a manifestation of their spiritual care (Bone et al. 2018, p. 217)." They define spiritual presence as accompanying and comforting. Citing Doona et al. (1999), they further defined nursing presence as, "uniqueness, connecting with the patient's experience, sensing, going beyond the scientific data, knowing what will work and when to act, and being with the patient (Doona et al. 1999, p. 57)." The authors consider presence to be an important aspect of nursing practice in much the same way physicians and chaplains consider it to be an important aspect of their respective practices.

Consistent Articulation of Chaplain Presence

In a study of chaplain documentation patterns in the electronic health record (EHR) at a single quaternary care medical center, chaplains used document flowsheets containing descriptors that could be selected individually or in combination with each other as part of the documentation of patient and family visits. In the sample ($n = 5153$), 69% recorded at least one pastoral service descriptor. In 66.22% of these records, a chaplain chose "relationship building" and in 34.38% of these records a chaplain chose "non-anxious presence" (Adams 2015). Both

terms could be more broadly understood to indicate presence, yet none of the descriptors the chaplains used in the EHR were defined, including relationship building and non-anxious presence. The descriptors' definitions and intended usages were left to the interpretation of individual chaplains, making consistent application of the descriptors in succinctly communicating spiritual care problematic.

Idler et al. (2015) studied, through self-reported data, how chaplains in a religiously diverse healthcare setting use their own specialized knowledge in caring for patients and families facing serious illness (Idler et al. 2015). In 1140 total chaplain encounters the activity labeled "ministry of presence" was recorded in 48.1% of the encounters, second only to "active listening" (92.0%). The chaplains in the study were trained to use the instrument used in the study, a digital diary, but it is unclear if training included discussion of the appropriate use of terminology describing these activities. The authors spoke of the frequency of these two activities as evidence of, "the consistency of training and common language" (Idler et al. 2015, p. 731) of the chaplains in the hospital. While that may imply that presence is a common descriptor of what chaplains do it does not reveal what presence is or its importance as a chaplain activity.

In a qualitative, textual analysis, retrospective chart review of 255 chaplain chart notes in the adult intensive care units at a major academic medical center, Lee et al. (2017) identified four primary themes of chaplain notes; frequent use of code language, describing observations rather than interpreting their clinical significance, passive follow-up plans, and sometimes providing insights into particular relationship dynamics (Lee et al. 2017). In code language, chaplains use recurrent words and phrases that seemed to reflect a larger commonly understood concept or activity. Cited examples of code language include compassionate presence, meaning-oriented presence, and continued presence and follow-up. The authors concluded that, at that institution, the use of these and other similar ambiguous terms were encouraged as means of communicating the work chaplains do (Lee et al. 2017).

In "Paging God, Religion in the Halls of Medicine," Cadge (2012) observed that chaplain relationships are less about religion and more about building a supportive relationship with someone, whoever they are, as they are. Cadge observes that the "emphasis on presence is much more general and much less concerned with any effort to validate that it has an effect (Cadge 2012, p. 94)." This makes it difficult to distinguish chaplain presence from that provided by nurses, doctors, social workers, and other members of the interprofessional team.

In summary, an accompanying and comforting presence that helps patients explore their sense of hope and meaning is provided by many healthcare disciplines. Chaplains tend to articulate their role, in general, and presence, specifically, by focusing on the process in the interactions with little consideration of the impact or outcome of the process while physicians tend to focus on outcome. There seems to be no concretely defined understanding of the concept of chaplain presence as something unique within healthcare. The next section synthesizes the literature into a working definition of chaplain presence in the healthcare setting.

Presence: A Working Definition

In "Thomas Jefferson: the Art of Power," Meacham (2012) records the first meeting between Thomas Jefferson and Mrs. Margaret Smith in the parlor of her and her husband's home. The manner in which Mrs. Smith recounts meeting appears to have implications for the environment and substance of chaplain use of presence in interactions. In this encounter, she did not know who he was and was being hostess to this visitor while her husband was concluding some other business.

> Such was his charm that though she did not know quite why, here she was, saying things she had not meant to say. "There was something in his manner, his countenance and voice that at once unlocked my heart." The caller was in a kind of control, reversing the usual order of things in which the host, not the hosted, set the terms and conditions of the conversation. "I found myself frankly telling him what I liked or disliked in our present circumstances and abode," Mrs. Smith said. "I knew not who he was, but the interest with which he listened to my artless details…put me perfectly at my ease; in truth, so kind and conciliating were his looks and manners that I forgot he was not a friend of my own (Meacham 2012, p. 25).

In recalling her conversation with Jefferson, Mrs. Smith used descriptors such as his ability to make her feel safe through his manner, countenance, and voice. She noted his interest was evidenced through his listening and this put her at ease (Adams 2015). In the conversation Jefferson created an atmosphere of ease for Mrs. Smith. Even though she did not know him, this sense of ease gave her the freedom to share important aspects of her personal life. This environment and exchange echo the care chaplains describe as presence. In providing presence, the chaplain seeks to quickly create an atmosphere of trust and ease conducive for sharing what the patient/family finds meaningful and important, often in the context of tense and terrifying circumstances. The chaplain's interactions are expected to have a high degree of flexibility with no apparent agenda. This flexibility and lack of agenda in an atmosphere of trust are meant to facilitate the patient/family sharing those meaningful and important parts of their story that they need to tell as opposed to the story the chaplain may otherwise want or need them to tell. This kind of presence allows for a wide variety of sharing out of the patient/family story begging the question of the non-medical dynamics directly and indirectly associated with a disease progression and course of treatment. The lack of agenda and high degree of flexibility may contribute to creating an atmosphere of ease and trust. Still they would not, of themselves, establish an atmosphere in which the patient and family can share and explore those meaningful and important parts of their story that they need to tell. The key component is emotional availability and emotional vulnerability. Further, they imply a lack of structure in chaplain interactions.

A working definition of chaplain presence, then, is a process through which the chaplain creates an atmosphere of ease and trust so that the recipient of the

chaplain's care can share their own story in an environment that is nonjudgmental and compassionate. This presence has no apparent agenda and a high degree of flexibility allowing for conversation that includes and transcends present health concerns. A key component in creating this environment is the chaplain's own emotional vulnerability in the interactions making the conversation a more mutual exploration into the stories of both the receiver of care and the care provider/chaplain.

This definition presents certain problems. First, to some degree, all members of the interprofessional healthcare delivery team provide presence in accordance with this definition. While there is typically more of a stated agenda with other disciplines, building an atmosphere of trust is vital to the caring relationship. Medical conversations explore family social dynamics and there is emotional vulnerability any time a provider gives an honest, thoughtful response to one of the most commonly posed questions to a healthcare provider, "If you were in this situation, what would you do?"

A second problem is the lack of agenda in the process. This is most concretely evidenced in Nolan's assertion of the need for no therapeutic aim in a chaplain conversation (Nolan 2011). The purpose of the conversation evolves and emerges on its own. Until an atmosphere of trust can be developed and an objective emerges, the conversation is largely dependent on the chaplain's emotional vulnerability. With no other structure to rely upon, maintaining appropriate boundaries in an interaction dependent upon a chaplain's emotional availability and vulnerability is problematic. Even if the chaplain has a high degree of self-awareness and practices a high degree of emotional, mental, spiritual, and physical self-care, there is an elevated risk of blurring the boundaries between professional and personal interactions. This can be especially problematic when the bulk of professional interactions concentrate on intense spiritual and emotional themes. One approach to addressing this concern may be focusing more on sensitivity to the emotional and spiritual dynamics in the interactions than on the chaplain's emotional and spiritual vulnerability and availability. In discussing cultural competence, Kodjo identifies principles guiding competence which include, "…empathy, curiosity, and respect, with which comes a heightened understanding and appreciation of the social context of the patient (Kodjo 2009, p. 58)." Using these same principles in providing chaplain presence could also provide more specific descriptors of this presence.

A third problem is communicating the importance of presence in patient/family interactions and its impact in healthcare. In an environment increasingly driven by evidence-based practice and health outcomes, it is even more important that chaplains articulate the impact of their care in these terms. Like other members of the interprofessional team, a chaplain's scope of practice occurs within certain parameters. Presence does not exist without bounds, but operates within parameters. These parameters, however, have yet to be defined. By defining these factors and operationalizing them to point to specific outcomes, chaplains could more effectively demonstrate the impact of practice. In addition, the structure that this would offer may provide more intentional guidance through chaplain conversations and minimize the impact of emotional vulnerability on professional boundaries. Further, clearly defining the parameters of presence, what it is as well as its actions and goals, may

contribute to articulating the unique qualities of chaplain presence. Finally, two central features of the role of the chaplain are the exploration of sacred presence and that of meaning making. Any discussion of the definition of presence, its parameters, and its outcomes should include these two features.

Fourth, this definition makes it difficult to concretely assess specifically how chaplain presence is applied, what it does, and how to articulate it within an interprofessional context. In a qualitative study, Massey et al. (2015) developed a taxonomy of chaplain activities and interventions as a step to creating a common language for communicating care to other chaplains and to the interprofessional team. Out of the study, they organized chaplain activities into a grouping of Intended Effects, Methods, and Interventions they referred to as a pathway. Chaplains choose items in each of the categories to create a specific pathway of care. There are no stated inherent relationships between items across the three categories and are selected according to chaplain assessment of the individual situation. The items in the taxonomy, therefore, "can be grouped and associated in nearly infinite combinations… (Massey et al. 2015, p. 5)" in the creation of care pathways. This approach maximizes flexibility for the chaplain generating these pathways. On the other hand, the lack of relationship between terms across these three categories would make evaluating a pathway's effectiveness and impact on patient care problematic. In addition, the lack of definitions for the terms in the taxonomy increases difficulty in consistently applying them in practice. Adams (2015) emphasized that the lack of definitions for terminology and the lack of defined relationships limited the evaluation of what chaplains were communicating in the EHR.

Presence: An Operational Definition

Building on the work of Massey and others, a next step in articulating what chaplains do in ways that can be effectively incorporated into evidence-based practice is to define key terms in ways that can be tested for their impact on patient care. Working within the existing structure for healthcare outcomes chaplains need to articulate well-defined specific goals, or Massey's intended effects, that can be evaluated to determine their direct or indirect impact on existing healthcare outcomes. The interventions used also require definition as well as connection to specific goals that can be determined through consistent assessment models.

Following this reasoning, a definition of chaplain presence is warranted that includes basic parameters for care and intended outcomes of this care. An operational definition of chaplain presence is establishing an environment of care based on empathy, curiosity, and respect in which the chaplain is attentive to the verbal and non-verbal two-way communication and assessing questions of the spiritual, the sacred, and of meaning providing concrete and appropriate psychosocial-spiritual interventions.

This operational definition includes four components: environment, care receiver and care giver response, chaplain assessment, and chaplain intervention (Table 1). Rather than depending on the chaplain's emotional availability and vulnerability she/he establishes an environment of care grounded in Kodjo's consideration of

Table 1 Operational definition of presence

Components	Environment	Care receiver/care giver response	Chaplain assessment	Chaplain intervention
Descriptors	Empathy, Curiosity, and Respect	Non-verbal exchange, Verbal exchange	Sacred linkage, Meaning-making	Intentional processes in response to assessment

empathy, curiosity, and respect for the care receiver's specific psychosocial–spiritual context (Kodjo 2009). Much like other healthcare disciplines, the chaplain is fully attentive to the verbal and non-verbal responses of the care receiver using both verbal and non-verbal communication in his/her responses (Daaleman 2012; Nolan 2016). If the care receiver is non-responsive, for example an unconscious patient in an intensive care unit, an understanding of the care receiver's context may be acquired through a third-party such as family, staff, or the patient chart. These first two components are a common expectation of all healthcare providers. The latter two may be unique to the role and function of the chaplain.

As the literature consistently demonstrated, spirituality and a sense of what is sacred to the patient/family are underlying components of presence and are often accompanied by the theme of meaning making. The chaplain assessment is unique in that spirituality, the sacred, and meaning-making are central to the chaplain interpretation of an encounter. Chaplain interventions would be concrete responses to the assessment intended to address specific outcomes. Examples of three such outcomes were identified by Lyndes et al. (2012); relieving spiritual suffering, improving family–team communication, and addressing spiritual needs.

This definition identifies presence as one approach to the provision of spiritual care. It could then be argued that, while important, presence is not a central component of the chaplain's professional identity. Some chaplain interactions would require different assessments and interventions. How and when presence is used would depend on the needs presented in a specific situation. It may be more accurate, then, to view this activity whatever its terminology, as a specific type of approach to the chaplain encounter. Defining presence in terms of an operational approach to care allows the opportunity to build testable constructs that can be used to assess the impact of chaplain interventions. This more operational approach to defining, articulating and evaluating presence as well as other dynamics of the chaplain role could add to the growing body of evidence demonstrating the impact of spirituality on health as an important non-medical component in the patient context.

Compliance with Ethical Standard

Conflict of interest The author has no conflict of interest associated with this review article.

Human and Animal Rights The developing of this review article did not involve research with human participants or animals.

Informed Consent Informed consent was not indicated in the developing of this review article.

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